CLINICAL VIGNETTE

The Three Questions and the Dynamics of Patient Change

By Brian S. Morris, MD

Case Report

The patient is a 46-year-old male with a past medical history significant for metabolic syndrome, asthma, and GERD. His blood pressures have been running on average 142/87 mm hg. over the past few months. Prior to that, his readings were mostly running in the normal range. He notes that he has gained 15 pounds over the past year. He's on prilosec 20 mg daily. He reports no drug allergies. His social history is remarkable for rarely exercising which he blames on work-related stress. He smokes a pack of cigarettes per day and he averages about 3-4 glasses of wine per day. His family history is remarkable for obesity, type 2 diabetes, and coronary disease.

His physical examination reveals a blood pressure of 148/86 mm hg., pulse of 74 beats/minute, height of 6 feet 1 ½ inches, and weight 218.6 pounds. Basal metabolic rate is estimated at 2057 calories per day. Fat percent is 26.3%. BMI is 28.5. His physical examination is generally unremarkable.

His labs reveal a fasting blood sugar 106 mg/dL, HDL-C 36 mg/dL, triglycerides 180 mg/dL, LDL-C 116 mg/dL.

After performing a physical examination, the patient and I discuss that his health (GERD, asthma, sugar control, etc.) would likely be improved if he were to give up cigarettes, as well as stop or significantly reduce his alcohol consumption.

General Discussion

Helping patients change their negative behaviors is one of the most challenging tasks for the clinician[1]. In addition to reviewing active medical problems, examining the patient, and ordering necessary diagnostic and screening tests, precious few minutes typically remain to address each patient's unhealthy habits. Poor eating habits, lack of exercise, excessive alcohol consumption, smoking, poor sleep habits, and excessive stress are just a few of the habits that patients often need addressed in the office setting. Many clinicians believe that they simply do not have sufficient time during the office visit to make a significant difference in patients' habits. Many also become frustrated when patients repeatedly fail in their attempts to make permanent, significant changes.

One of the most well known and helpful models created to help clinicians better understand the "change process" was formulated by Prochaska and associates[2]. This model defined the stages of change that occur within the mind of the patient. These stages include pre-contemplation, contemplation, preparation, action, maintenance, and relapse. An understanding of these stages of change has been extremely useful in regard to addictions such as smoking, alcohol abuse, and drug abuse[1]. This model has also been successfully applied to nutritional habits in relation to diabetes[3] and obesity[4]. A full understanding of these stages helps the clinician to better understand where the patient is in his/her "change process" and to tailor suggestions to best meet the patient's needs[5].

When clinician's apply Prochaska's model to clinical practice, they often find that this model has some limitations despite its benefits. First, the model mainly deals with change as it occurs within the patient's thought system. It assumes that the patient is an isolated entity needing to go from point A to point B and the clinician is simply the provider of information that is needed for the journey. Clinicians know that patients do not make decisions in isolation – they function as part of relationships, families, communities, etc. In addition, the patient makes decisions in the context of the patient/clinician alliance – the partnership between patient and clinician. From my experience, the clinician serves a much more significant role in the change process than what is described in Prochaska's stages and is much more of an active and dynamic participant in the change process. Patients need a trusting and supportive relationship with the clinician. A steady, positive, caring alliance between patient and

clinician is paramount to helping patients change. Secondly, Prochaska's model holds that patients travel a straight line journey of change from one behavior to another: from pre-contemplation to contemplation to preparation to action and so on. From my experience, this is not the way that change happens for most patients. Most patients move through each of these stages simultaneously or sometimes out of order. Patients think about their habits (contemplation) while they prepare to make a habit change (preparation) while they act to change their habits (action). Thus, patient change is a dynamic, non-linear, and integrative process involving a partnership grounded in trust, connection, and caring. Third, Prochaska's stages of change are descriptions of where patients are within the change process, but such knowledge, although helpful, does not readily help the clinician know how best to support the patient. A system that better helps clinicians to support patients to change negative behaviors should be simple and should readily and naturally guide the clinician on what sort of support and guidance is needed at that time.

Over my years of clinical practice, I have developed a system that has been very helpful in helping patients change negative behaviors. Rather than describing the patients' stages of change, I have found that a more clinically useful tool is to focus on three question words that drive human behavior. Questions are easy for the clinician to remember in the midst of a busy day and conversations with patients flow naturally from such questions. These are three question words that I use in the office setting to help patients change their negative behaviors.

Before I discuss the three question words, I need to emphasize that the first step to help a patient change a habit is to establish a meaningful, trusting, and supportive environment so that the patient feels comfortable enough to discuss and consider changing himself or herself. The patient must know that the clinician, without question, is a trusted source of help and is aligned with the patient's best interests. There are many practical suggestions for how clinicians can foster a trusting, supportive environment for the patient but a full discussion of these suggestions is beyond the scope of this article. Suffice to say, people tend not to change when they feel judged or treated like a child. People are more likely to change when they are given respect, understanding, and compassion. One of the best ways that I know to improve our skills in this regard is to videotape an office visit (with the patient's consent). Seeing our facial expressions, hand gestures, etc. can help us to dramatically improve how we communicate to our patients.

Once this trusting alliance is created, the patient and clinician are now "partners" in the change process. In addition to trust, sufficient time is also necessary to help patients change. Very few patients will change a habit over night. More commonly, patients need to hear messages from the clinician (and from others) many times. As I review the three questions, please remember that each of these questions typically needs to be addressed repeatedly over multiple office visits. Sometimes all three questions can be addressed during one office appointment. In other circumstances, the clinician may choose to focus on one question over several office appointments. How and when the clinician applies the three questions depends on the clinical situation and the "art" of medical practice.

Here are the three question words:

Question 1: <u>Why?</u>

The first set of questions for the clinician to use to help facilitate patient change are the "why" questions. Why is the patient practicing this behavior that's not healthy? Why has the patient not stopped practicing this behavior? Why should the patient change the behavior? People don't change their behaviors until there is a compelling and overriding "why" in their mind. It needs to be specific and it needs to be compelling. It can't be an "I might get cancer one day" or "smoking is bad for me". Hence, the "why" step is rarely a one-time discussion. The clinician needs to understand the patient's motivations, needs, and past history to get a read on what which reasons are most compelling to each individual patient. This takes time, This takes clinical insight. This takes listening. Patients will often tell you what their "why" is but we need to be listening when it comes up. The answer to why the patient should change the behavior might be that he/she wants to see his children graduate from college. Alternatively, it might be that he/she is terrified of dying from emphysema like his father did. The answer to why the patient continues to smoke might be that it helps ease his/her anxiety and

stress. Our job is to be a clinical detective and figure out what the "why's" for each patient and for each habit that we want the patient to address. In clinical practice, the clinician can simply ask a "why" question and then let the patient talk. For example, one might ask "why did you first start smoking?". Our job is to help the patient to become fully conscious of and fully integrate these motivations and needs.

Question 2: <u>When?</u>

The next set of questions involve helping the patient figure out the timing of a potential change. This set of questions involve "when" questions. In the field of addiction, the term "quit date" has been used for many years. Although a "quit date" has some appeal in the change process, I find it more effective to focus on which behaviors a patient is ready to change at the present time, rather than setting a future quit date. I've found that when a patient is ready to change, a quit date isn't often necessary. Also, quit dates tend not to be helpful if the patient isn't truly ready to make a change. Rather than focusing on a quit date, I like to use the analogy of "low-hanging fruit" when I discuss timing with a patient. Typically, the best habit to address from a practical perspective is the one that seems most easy for the patient to change at that time - it's the fruit that's simply ready to be picked (the "low-hanging fruit"). If a patient has three or four habits that need to be changed, sometimes it's best to simply ask the patient which would be easiest to change. Changing a deeply ingrained habit is difficult work so addressing the one that seems to be most "ripe" is a often a savvy, clinical move. In clinical practice, the clinician can simply ask a "when" question and then let the patient talk. For example, one might ask "when might be a good time to stop smoking?" Again, our job is to facilitate the patient becoming fully conscious of and fully integrating the answer to this and other questions.

Question 3: <u>How?</u>

The next set of questions are "how" questions. These questions are the one that most people think about in regard to helping a patient change a behavior. This question often involves figuring out how the patient can actually go about making a change. These are the nuts and bolts questions about making a change. If a patient needs to stop smoking, we tend to think about various resources that can help (nicotine gum, nicotine patch, oral medications, 12-step groups, etc.). Many of these "how" questions can be quite helpful in making the change process easier and more likely to succeed. However, most clinicians know that change does not typically happen when a patient learns more about the logistics of making a change. People tend to change when they decide that the timing is right. In other words, people change when the why's become so convincing that change simply happens.

These three sets of questions are simple and easy to remember and naturally feed into deeper conversations about the habit in question. When I work with patients in regard to changing a behavior, these three sets of question are constantly in my mind. Sometimes I'll bring up all three within one conversation. Sometimes I'll bring up only one. The three questions can sometimes relate to specific stages of change. However, patients don't typically think in terms of stages of change. They think in terms of questions – often asked internally. They may think "why should I stop smoking?" If the internal answer isn't compelling then the internal dialogue often ends there. If the patient has a compelling answer to the "why" question then he/she often moves onto the next question which is often a "when" question. For example, "when should I stop smoking"? If there's no compelling time, then the internal dialogue may end there. However, if there is a compelling time, then the internal dialogue shifts to the next question and the patients asks "how?" If there's an answer to this and the patient has sufficiently answered the previous two questions then change is likely to happen.

Our job as clinicians is to continually support our patients in their internal journey to answer these three sets of questions. Each of these sets of questions relate both to practicing the habit and also potentially giving up the habit. For example, when discussing the habit in question with a patient, the clinician should ask questions that address "why" they should stop the habit and also "why" they have continued to pursue this habit over time.

Also, the art of practice is knowing when it is the right time to address a given question. Should we focus on one question at a time with a given patient? Should we discuss all three in one conversation? There's no hard and fast rule on this and I advise

clinicians to let the conversation flow naturally and patients will typically make it clear when a given set of questions can be addressed. All of this takes experience, a willingness to listen, and trusting one's clinical instincts.

Resolution of Clinical Scenario

During the next office visit, I asked the patient some simple "why" questions in regard to why he continues to smoke and consumer 3-4 glasses of alcohol per day. We also discussed why stopping has been so difficult. This led to an honest discussion of his childhood and how his father's drinking affected him and his entire extended family. I also chose to ask some "when" questions in regard to his prior attempts to stop and why he was unsuccessful. I chose not to pursue a "how" question during that appointment but in subsequent visits we continued to explore the "why" and "when" questions. After a few more visits, I sensed that he was starting to be ready to address the "how" questions and we started to brainstorm ideas for how he might try to give up the alcohol. In addition to discussing a potential quit date, we continued to discuss the role that alcohol has in his life and what else in his life might fill those needs. We had many more discussion where we continued to discuss the "why", "when", and "how" questions related to his alcohol drinking and smoking. After many discussions and after he felt strong enough to try, my patient entered a detox center and hasn't had a drink (or a cigarette) since then. It's been a year now and hopefully this will continue. When I see him in the office now, I continue to use the three questions as we discuss the challenges that he still faces and how he copes. We discuss that relapse is always a real possibility and our continued discussions of the "why", "when", and "how" questions have helped prevent possible relapses. As he's gained strength and confidence, we have just started discussing some of his other habits, which he hopes to address in the future.

Take Away Pearls

1. The clinician can help the patient change negative behaviors by facilitating discussions in regard to three simple sets of questions.
2. These questions represent a non-linear, dynamic, integrative approach to facilitating patient change in the office setting.
3. The three sets of questions relate to "why", "when", and "how".
4. The clinician can use this model in clinical practice to help patients move towards healthier habits.

REFERENCES

1. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. Applications to addictive behaviors. Am Psychol. 1992 Sep;47(9):1102-14.
2. Prochaska JO, DiClemente CC. Stages of change in the modification of problem behaviors. Prog Behav Modif. 1992;28:183-218.
3. Salmela S, Poskiparta M, Kasila K, Vähäsarja K, Vanhala M. Transtheoretical model-based dietary interventions in primary care: a review of the evidence in diabetes. Health Educ Res. 2009 Apr;24(2):237-52. Epub 2008 Apr 11.
4. Greene GW, Rossi SR, Rossi JS, Velicer WF, Fava JL, Prochaska JO. Dietary applications of the stages of change model. J Am Diet Assoc. 1999 Jun;99(6):673-8.
5. DiClemente CC, Prochaska JO, Fairhurst SK, Velicer WF, Velasquez MM, Rossi JS. The process of smoking cessation: an analysis of precontemplation, contemplation, and preparation stages of change. J Consult Clin Psychol. 1991 Apr;59(2):295-304.

Submitted on July 21, 2011